STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING
APPLICATION FOR LICENSURE

PODIATRIC PHYSICIAN

DOPL-AP-002 REV 05/29/2001

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Division desires to provide courteous and timely service to all applicants for licensure. To maximize its efficiency and level of service, the Division will process complete applications only. **A complete application includes all applicable supporting documents and fees.** The fees are for processing your application and will not be refunded. Failure to complete the application and supply necessary information may result in denial of licensure. Please read all instructions carefully.

Address of Record: The address listed on the application will be your address of record. All correspondence from the Division will be sent to that address. It is your responsibility to directly notify the Division of any change in address. Please note that the address of record is public information and is available upon request and via the internet. You may choose to use a business address or a P.O. Box for your address of record rather than your home address.

Social Security Number: Your social security number is classified as a private record pursuant to Title 63, Chapter 2, Utah Government Records Access and Management Act (GRAMA). It is used as an individual identifier for our licensing database and for purposes of the child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements the requirements of 42 U.S.C. 666(a)(13). An application that does not include a social security number is incomplete and cannot be processed.

Supporting Documents and Fees:

1. Submit an official transcript from a college of podiatric medicine accredited by the Council of Podiatric Education, which includes your date of graduation and degree earned.

2. Submit an "Evaluation of Postgraduate Training" form from each of your residency programs to document having successfully completed at least 12 months of postgraduate training in a program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

   Request that the Residency Director complete the form and mail it directly to the Division. Evaluations will not be accepted from administrative personnel. Letters of recommendation will

not be accepted in lieu of the evaluation form.

3. Using the "Request For Verification of License" form, obtain verification of licensure from every state in which you have ever been licensed as a podiatrist.

   Request that the verifying state(s) complete the form(s) and mail or fax them directly to the Division or return them to you for submission with your application.

4. Submit the original letter from Experior documenting your passing score on the Utah Podiatric Law Exam.

5. Submit an official score report from the National Board of Podiatric Medical Examiners Examination (NBPME) verifying your having passed the National Examination.

6. Submit an official score report from the Podiatric Medicine Licensing Examination verifying a passing score on the PM Lexis, unless you are applying by endorsement.

7. If you are applying for licensure by endorsement, additionally submit the following documentation:

   - Verification that you are currently licensed in another state;

   - Verificiation that you have been licensed as a podiatric physician in the jurisdiction issuing the license for at least the last two years immediately preceding the date of this application.

8. Submit the $100.00 non-refundable application processing fee for a Podiatric Physician license.

   Please Note: As of July 1, 2001 the Podiatric Physician application fee will increase to **$130.00**.

9 If you are applying for a Utah controlled substance license, submit the following.

   - The original letter from Experior documenting your passing score on the Controlled Substances Law and General Law Examination.

   - The $90.00 non-refundable application processing fee for a Controlled Substance License.

Additional Important Information:

1. **Law and Rules Exam:** All applicants for licensure must pass the Utah Podiatric Physcian Law Examination. Contact Experior at the address and telephone number below to register for the examination.
   Experior, 5486 South 1900 West, Suite C, Taylorsville, Utah 84118, (801) 355-5009.

The Controlled Substances Law Examination is also administered by Experior. For registration and fee information, contact them directly at the address and telephone number above.

You may also purchase a study guide from Experior which has been prepared to assist candidates taking law exams.

In addition, the following applicable laws and rules are available on the Internet at http://www.commerce.state.ut.us/dopl/dopl1.htm

- Division of Occupational & Professional Licensing Act
- General Rules of the Division of Occupational & Professional Licensing Profession Licensing Act
- Utah Podiatric Physician Licensing Act
- Utah Podiatric Physician Licensing Act Rules

2. **National Examination:** For registration and fee information or to request a score report, contact the National Board of Podiatric Medical Examiners (NMME) at P.O. Box 510, Bellefonte, PA, 16823, PHONE: (814) 357-0487, FAX: (814) 357-0581, E-MAIL: NBPMEOfc@aol.com

3. **PM Lexis:** For registration and fee information or to request a score report, contact Experior at the address or telephone number above.

4. **Examination Fees:** There are separate fees for all examinations. It is the responsibility of the applicant to submit the fees directly to the testing agency.

5. **Controlled Substance License:** You must hold a Utah controlled substance license **and a** DEA registration to administer, possess, or prescribe a controlled substance in your practice of podiatric medicine in Utah.

6. **DEA Registration**: For DEA registration information, contact the Drug Enforcement Administration at (800) 326-6900.

7. **License Renewal:** Each podiatric physician license expires September 30 of each even numbered year. In order to renew your license you must complete at least 40 hours of qualified continuing education.

8. **Updating Address Information:** It is a licensee's responsibility to maintain a current address with the Division. If your address is incorrect, you will not receive renewal notices or other correspondence.

Make Licensure Fees Payable To:

DOPL

Mail Complete Application To:

By U.S. Mail

Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741

By Delivery or Express Mail

Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111

Telephone Numbers:

Direct Dial:	(801) 530-6623 or (801) 530-6633
Utah Toll Free:	(866) ASK-DOPL (866) 275-3675
Fax Number:	(801) 530-6511

APPLICATION FOR LICENSE or CERTIFICATE or REGISTRATION

GENERAL INFORMATION

License/Certificate/Registration Applying For: _____

Social Security Number: _____

Last Name: _____Maiden Name:_____

First Name: _____Middle Name: _____

Have You Ever Held A Utah License Before? Yes_____ No_____

If Yes, Name of Profession: _____

If Yes, License Number:_____

Gender (Male or Female):_____Date of Birth:_____

PUBLIC MAILING ADDRESS

Street:_____

City:_____State:_____Zip:_____

County:_____

Telephone:_(____)_____

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved:_____

Approved By: _____

Date License/Certificate Denied: _____

Denied By: _____

Reason For Denial/Other Comments: _____

APPLICATION FOR:

_____ Podiatric Physician License

_____ Controlled Substance License

MEDICAL SCHOOL (Use additional sheets if necessary):

Name: _____ Dates Attended: _____ To _____

Location: _____

Degree Received:_____ Date of Graduation: _____

GRADUATE MEDICAL EDUCATION OR TRAINING:

Complete the information below and account for **all** periods of training or postgraduate work from the time you graduated from podiatric school. Use additional sheets if necessary.

Name of Hospital: _____

Address of Hospital: _____

Department: _____

Date Began: _____ Date Ended:_____

Position (Intern, resident, fellow): _____

Name of Hospital: _____

Address of Hospital: _____

Department: _____

Date Began: _____ Date Ended:_____

Position (Intern, resident, fellow): _____

Name of Hospital: _____

Address of Hospital: _____

Department: _____

Date Began: _____ Date Ended:_____

Position (Intern, resident, fellow): _____

PROFESSIONAL WORK EXPERIENCE:

Please list your professional work experience. **Account for all periods of time since you completed your post-graduate training.** Use additional sheets if necessary.

_____

_____

_____

_____

_____

_____

PROFESSIONAL EXAMINATION REQUIREMENT:

Answer "yes" or "no"

_____NBMPE, Date(s) Taken: _____

_____PMLexis, Date(s) Taken: _____

_____Utah Podiatric Law Exam, Date(s) Taken: _____

_____Utah Controlled Substances Exam, Date(s) Taken: _____

_____State Exam: State Taken: _____Year Taken: _____

LICENSES:

List all licenses, registrations, or certifications issued by any state which you now hold or have ever held in any health care profession. Use additional sheets if necessary.

Issuing State: _____

Profession:_____

Issuing State: _____
Profession:_____

Issuing State: _____

Profession:_____

Answer “Yes” or “No”

_____I have been licensed as a podiatric physician for at least 2 years immediately preceding the date of this application.

IF APPLYING FOR A CONTROLLED SUBSTANCE LICENSE:

I hereby agree to comply with the laws of Utah relating to the Controlled Substances Act and Rules.

Signature of Applicant: _____

Date of Signature:_____

PODIATRIC PHYSICIAN
QUALIFYING QUESTIONNAIRE

Answer "yes" or "no" for each question. Do not leave any question blank.

1. _____Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?

2. _____ Have you ever been denied the right to sit for a licensure examination?

3. _____Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

4. _____Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any professional licensing agency or criminal or administrative jurisdiction?

5. _____Are you currently under investigation or is any disciplinary action pending against you now by any professional licensing agency?

6. _____Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

7. _____Have you ever been permitted to resign or surrender hospital or other health care facility privileges while under investigation or while action was pending against you by any health care profession licensing agency, hospital, or other health care facility or criminal or administrative jurisdiction?

8. _____Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?

9. _____Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

10. _____Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any health care profession licensing agency, hospital, or other health care facility or criminal or administrative jurisdiction?

11. _____Is any action pending against you now by Medicaid, Medicare, or any other state or

federal health care payment reimbursement program?

12. _____Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?

13. _____Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility or criminal or administrative jurisdiction?

14. _____Is any action pending against you now by either the federal Drug Enforcement Administration or any state drug enforcement agency?

15. _____ Have you been named as a defendant in a malpractice suit?

If you answered Ayes@ to question 15, for each malpractice suit filed against your license, supply the date, status, disposition, amount of settlement, and a detailed description including your relationship to the patient and your role in the case.

16. _____Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?

17. _____Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?

18. _____If you are licensed in the health care profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?

19. _____Are you currently using or have you recently (within 90 days) used any drugs (including recreational drugs) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?

20. _____Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which you have not successfully completed or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?

21. _____Have you been arrested for or charged with a misdemeanor or felony charge in any

jurisdiction during the last 10 years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.

22. _____Have you ever pled guilty to, no contest to, or been convicted of any felony or misdemeanor in any jurisdiction?

If you answer "yes" to question 21 or 22 you must include with your application a copy of the police report, court docket, and any probation/parole officer report for EACH and EVERY arrest and/or conviction within the past ten years.

23. _____Have you ever been involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?

24. _____ Have you ever been terminated from a position because of drug use or abuse?

25. _____ Have you ever been incarcerated for any reason in any Federal, State or County Correctional Facility?

If you answered "yes" to any of the above questions, please enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

A "yes" answer does not necessarily mean that you will not be granted a license; however, additional documentation may be requested by the Division if the information submitted is insufficient.

AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division in conjunction with this application or its supporting documents meets the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

I understand that this application will be classified as a public record and will be available for inspection by the public, except with regard to the release of information which is classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Applicant:_____

Date of Signature:_____

Printed Name of Applicant: _____

Division of Occupational & Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741

EVALUATION OF POSTGRADUATE TRAINING

TO BE COMPLETED BY APPLICANT: Request that the Residency Director complete this form and mail it directly to the Division. Evaluations will not be accepted from administrative personnel. Letters of recommendation will not be accepted in lieu of this form.

Applicant Name: _____

Applicant Address: _____

Name of Evaluating Hospital/Institution: _____

Department: _____From (Mo/Yr)_____To (Mo/Yr) _____

Type of Postgraduate Training: _____Internship _____Residency _____Fellowship

I hereby authorize release to the Utah Division of Occupational and Professional Licensing any files, records or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure as a physician and surgeon.

Applicant Signature: _____Date: _____

TO BE COMPLETED BY EVALUATING PHYSICIAN:

Name of Evaluating Physician (Please Print): _____

Title:_____Phone No.:_____

This evaluation is based on: _____ Personal Knowledge _____ Review of Credential File

How long have you known the applicant? years_____months _____

Is this training program accredited by the Council on Podiatric Education? _____Yes _____No

Please answer "yes" or "no" for each question. Please do not leave any question blank.

1. _____Are the dates provided by the applicant on the top portion of the form accurate?
If no, please indicate the period of program: From _____/_____To _____/_____

2._____Is the applicant related to you?

3. _____Do you know the applicant well?

4._____Has your acquaintance with applicant continued until recent dates?

5. _____Do you consider the applicant reliable?

6. _____Do you consider the applicant ethical?

7. _____Do you consider the applicant to be of good character?

8. _____Has the applicant, to your knowledge, ever been guilty of fraud or dishonesty?

9. _____Has the applicant, to your knowledge, ever been guilty of unprofessional conduct?

10. _____If the English language is not the native language of this applicant, do you feel that he/she has the ability to adequately communicate in the English language?

11._____To your knowledge, has the applicant ever been warned, censored, disciplined, had admissions monitored or privileges limited?

12. _____To your knowledge, has the applicant ever been asked to leave a training or post-graduate program?

13._____Did the applicant successfully complete this training program?

14._____Do you have any reservations about recommending the applicant for licensure? If yes, please explain on attached sheet.

15._____Is there anything else you think we should be aware of in evaluating this applicant for licensure? If yes, please explain on attached sheet.

16. Please rate the applicant=s:

Professional Ability: ____ Excellent _____Good _____Average _____Adequate _____Poor
Attention to Duties: ____Excellent _____Good _____Average _____Adequate _____Poor
Breadth of Education: ____Excellent _____Good _____Average _____Adequate _____Poor
Interpersonal Skills: ____Excellent _____Good _____Average _____Adequate _____Poor

All reports received by the Division of Occupational and Professional Licensing on a licensure applicant are confidential and are not subject to disclosure. However, the board must disclose such reports if

they are relied upon in a contested denial of licensure.

Evaluating Physician=s Signature: _____ Date:__ _____

Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
FAX: 801-530-6511

REQUEST FOR VERIFICATION OF LICENSE

TO BE COMPLETED BY THE APPLICANT:

Request that the verifying state complete the form and mail or fax it directly to the Division or return it to you for submission with your application

Applicant Name: _____

Street Address: _____

City: _____

State:_____ Zip: _____

I am requesting licensure in the State of Utah as a _____

I am/have been licensed in your State under the name _____

My Social Security Number is _____

My Date of Birth is _____

My license number in your State is/was _____

I have enclosed the necessary license verification fee in the amount of $ _____

Signature of Applicant: _____

TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail or fax it directly to the Division or place the completed form in an envelope, seal the envelope and provide it to the applicant in

person or by mail. The applicant will include the verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: _____

Name of Licensee (as it appears in verifying state's records): _____

Classification of License Issued:_____

License Number: _____

Current Status: _____

Original Date of Licensure:_____

Expiration Date: _____

Continuously Licensed:

_____Yes _____No, please elaborate_____

Licensed By:

_____Exam, Type:_____Date: _____

_____Endorsement, From What State: _____

Examination Scores:_____

Education Required For Licensure:_____

Disciplinary Action or Pending Disciplinary Action:

_____No _____Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____

Title:_____

Agency:_____

Date: _____

(SEAL)

Division of Occupational & Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114 - 6741

REQUEST FOR A FPMB DISCIPLINARY REPORT

APPLICANT INFORMATION: To be completed by applicant and sent to:

Federation of Podiatric Medical Boards
PO Box 880187
Boca Raton FL 33488-0187
(561) 477-3060

Name:_____

Address:_____
Date of Birth:_____
Social Security Number:_____

Medical School of Graduation:_____

Date of Graduation:_____

Please note a $40.00 fee will be charged for data bank reports. A return-mail confirmation postcard will be provided upon request. A $20.00 fee will be applied to any data bank inquiry presented through certified or registered mail, or for express mail when the receipt signature requirement has not been waived. The fee compensates the Federation for the extra costs involved in processing and signing return receipt forms. (Make checks payable to FPMB).

I am seeking licensure as a podiatrist in Utah. Please send a disciplinary data bank report to:

By U.S. Mail: Division of Occupational & Professional Licensing, P.O.Box 146741, Salt Lake City, Utah 84114-6741.

By Delivery or Express Mail: Division of Occupational & Professional Licensing, 160 East 300 South, 4th floor, Salt Lake City, Utah 84111.

Fax: (801) 530-6511

I have enclosed the appropriate fee.

Signature of applicant:_____ Date:_____